

IVC. National Performance Measures

National Performance Measure 01: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Last Year's Accomplishments

The Department of Health (DOH) established and convened a Cystic Fibrosis Technical Review Committee in response to a motion adopted by the State Board of Health (SBOH). The committee reviewed available information about the benefits of newborn screening for cystic fibrosis and made a preliminary determination regarding whether this condition meets criteria established for newborn screening tests in Washington. The committee found sufficient evidence for screening newborns for cystic fibrosis.

The Newborn Screening Program presented information to SBOH regarding the American College of Medical Genetics (ACMG) recommendations for a uniform national newborn screening panel.

DOH implemented real-time polymerase chain reaction in the Newborn Screening Laboratory to help refine the diagnosis and clinical prognosis of galactosemia, MCAD deficiency, and a clinically significant hemoglobinopathy (a form of alpha thalassemia). This allows us to obtain DNA results in far less time and at a lower cost.

CHILD Profile mailed a Health & Development Record booklet to approximately 80,000 families, which represents about 86 percent of the annual births in Washington. The booklet includes a message encouraging parents to talk with their health care providers about health screenings and provides a centralized area to record information about screenings such as newborn blood spot and hearing screening, vision screening, and lead screening. The Health & Development Record booklet is available in English and Spanish and is distributed as part of the introductory packet that arrives 4-6 weeks after an infant is born. CHILD Profile asked several parent and professional review teams for input on the usefulness, layout, and information contained in the record. CHILD Profile made significant revisions to the record and began mailing the new version in May 2005. (Fig. 4a, NPM 1, Act. 3)

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor every non-military infant born in Washington for appropriate screening and follow up on those with incomplete testing.				X
2. Contract with pediatric specialists and comprehensive care clinics to provide expert diagnostic and treatment services for infants with abnormal screening results.				X

3. Update and develop new professional and lay educational information via different venues: Web sites, provider manuals, on-site hospital visits, disorder-specific fact sheets and pamphlets, etc.				X
4. Determine family eligibility for financial and support services and coordinate through state and county CSHCN programs and medical homes.		X		
5. Purchase and distribute medically necessary formulas and low-protein foods for individuals with PKU and other metabolic disorders.		X		
6. Collect long-term outcome data to evaluate the benefit of various components of treatment, compliance, and intervention.				X
7. Develop a data system linking newborn screening records with hearing screening.				X

Current Activities: (Oct 1, 2005 – Sept 30, 2006)

Subsequent to the findings of the Cystic Fibrosis Technical Review Committee during the previous reporting period, DOH convened an advisory committee broadly representative of those with interests in infant health. The group evaluated cystic fibrosis (CF) in the context of the criteria that SBOH adopted to evaluate conditions for inclusion in the screening battery. This group concluded that CF met the criteria and recommended that the Board revise the screening regulations to include CF in the mandatory newborn screening panel. The Board accepted the recommendations. At a public hearing on December 7, 2005, SBOH voted unanimously to revise the regulations and directed DOH's Newborn Screening Program to implement the new screening as quickly as feasible and no later than June 2006.

Following the Board's decision to add CF to the screening panel, the Newborn Screening Program worked to obtain the necessary equipment and develop screening protocols. The Newborn Screening Program worked closely with the region's cystic fibrosis clinical treatment and diagnostic centers to develop linkages to services and follow-up protocols.

The Newborn Screening Program implemented cystic fibrosis screening for all infants born in Washington on March 15, 2006.

During this year, the Newborn Screening Program continued to expand and refine our screening protocols, particularly for the new disorders (including cystic fibrosis) added to the newborn screening panel. Necessary adjustments and revisions are being made based on department experience and that of other newborn screening programs.

The Newborn Screening Program and SBOH filed the paperwork necessary to begin considering the additional disorders recommended by the ACMG report.

CHILD Profile continues to distribute a Health & Development Record booklet as part of the introductory packet sent to Washington State parents 4-6 weeks after the birth of an infant. (Fig. 4a, NPM 1, Act. 3)

Plan for the Coming Year: (Oct 1, 2006 – Sept 30, 2007)

DOH's Newborn Screening Program will continue to work with SBOH to consider each of the 16 disorders in the ACMG report that are not in the current newborn screening battery for Washington. The plan calls for a review of medical issues through a technical advisory committee followed by a broadly representative Newborn Screening Advisory Committee. SBOH will consider the findings and recommendations of these groups.

The Newborn Screening Program will work with policy staff to convene a work group that will review the adequacy and stability of funding needed to support clinical care for children detected through newborn screening. The group will also look at funding sources and may recommend changes to the funding system.

CHILD Profile will continue to distribute its Health & Development Record booklet as part of the introductory packet sent to Washington State parents 4-6 weeks after the birth of their child. (Fig. 4a, NPM 1, Act. 3)

National Performance Measure 02: The percent of children with special health care needs age 0 – 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN Survey)

Last Year's Accomplishments:

The Children with Special Health Care Needs (CSHCN) section contracted with Children's Hospital and Regional Medical Center (CHRMC) to publish local and statewide data from the National Survey of CSHCN, county profiles, and other data sources. CSHCN introduced the publication at a conference in May 2005 and released it in July 2005. (Fig. 4a, NPM 2, Act. 1)

The CSHCN section promotes the family perspective in policy and program development and employs a full-time family consultant. At the fall 2004 Family Leadership Institute, parents attended sessions on national performance measures, MCH data, and the National Survey of CSHCN. Family leaders partnered with Title V, Child and Adolescent Health Measurement Initiative, Family Voices, and the National Center on Cultural Competence to conduct workshops to increase parents' knowledge and use of data. Pre- and post-conference surveys provided information on ways to involve family leaders in decision-making and integrate systems of care.

CSHCN supported parents in taking leadership roles in the Washington Integrated Services Enhancement Grant (WISE) that ended in August 2005. Agencies, community organizations, and other family support programs developed partnerships through work related to the WISE grant. Grant participants incorporated family input and ultimately recommended shared care

coordination, common application, integrated data, and blended funding strategies for system integration.

The CSHCN section collaborated with the Washington Family to Family Network (WFFN) to develop a statewide Family Leadership Plan. WFFN refined its vision and purpose statement and addressed strategic planning around the national performance measures. CSHCN helped develop cross-agency linkages on the WithinReach (formerly Healthy Mothers, Healthy Babies (HMHB)) Answers for Special Kids (ASK) Line Web site, and facilitated adding pictures of fathers and youth to ASK Line materials. CSHCN contracted with WithinReach's On-Line Access Project (OLAP) to involve parent consultants in ensuring that the WISE grant recommendations were followed.

Local CSHCN Coordinators continued to work with families to make decisions about care and services for children. The CSHCN Communication Network continued to involve parent organizations and parents. Meetings during this time focused on transition from early intervention programs to school; Supplemental Security Income (SSI) for children; the foster care system; and collaborations between public health nurses and families.

The CSHCN section contracted with Washington State Parent to Parent, and Washington State Fathers Network to provide statewide support and resource information to parents of children with special needs. A contract with the Center on Human Development and Disability (CHDD) at the UW helped support parents as members of feeding teams. Guidelines on the development of community-based feeding teams were revised and posted electronically. (Fig. 4a, NPM 2, Act. 2)

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with MCH Assessment to provide ongoing analysis of available data on children with special needs, including the NS-CSHCN, the NS-Children's Health and other Washington State data sources.				X
2. Ensure family representation in policy development through Medical Home Leadership Network, local health jurisdictions (LHJs) and other contractors, partnership with Washington Family to Family Network and through ongoing dialogue at CSHCN Communication Network meetings.				X

Current Activities:

The CSHCN section contracts with CHRMC to review available data and develop evaluation measurements for six performance measures. (Fig. 4a, NPM 2, Act. 1)

The CSHCN section and the section's family consultant continue to promote inclusion of the family perspective in all Office of Maternal and Child Health (OMCH) programs, activities and planning. The CSHCN section, through its new strategic plan and the work of the family consultant, continues to take a leadership role in identifying and implementing strategies to increase the number of families involved as decision-makers and who are satisfied with the services they receive. Program contractors involve families as an integral component to achieving and measuring satisfaction with services.

The CSHCN section and the WFFN updated the Family Leadership Plan/Logic Model to include integrated cross-program and cross-contract work and opportunities within the national performance measures. CSHCN conducted a survey to identify the types of family leadership training activities being implemented statewide and assess CSHCN-funded Web sites. CSHCN partnered with Family Voices to develop the Family to Family Health Information Center, and played an active role in developing the On Line Access Project and HMHB name change. Family advisors continue to be recruited and mentored. They are given opportunities for leadership roles in work related to Medical Home and Adolescent Transition, Bright Futures, Family Voices, On Line Access Project, Autism Task Force, Family Leadership Team, and Family to Family Health Information Center. The CSHCN and Genetic Services sections provided scholarships for parents to attend the Infant and Early Childhood Conference (IECC); Fetal Alcohol Spectrum Disorders State Retreat; Early Hearing Loss Detection, Diagnosis, and Intervention (EHDDI) Summit; and the Duncan Seminar.

Parent involvement as regular participants and as special presenters continues at the CSHCN Communication Network meetings. Meetings during this current year highlighted: health plans' educational offerings; care coordination and coverage for children with special needs; premature and low birth weight infants; emergency preparedness for the general public and specific preparation for children with special needs; and the state's early learning initiative.

CSHCN continues to support a network of community-based feeding teams that include parents as members through a contract with CHDD. (Fig. 4a, NPM 2, Act. 2)

Plan for the Coming Year:

The CSHCN section staff will work with MCH Assessment to provide ongoing analysis of available data on family satisfaction and involvement, including NS-CSHCN, the NS-Children's Health and other Washington State data sources. (Fig. 4a, NPM 2, Act. 1)

The inclusion of a family perspective in all OMCH programs, activities, and planning will remain a priority for the CSHCN section. Efforts to identify opportunities and implement strategies to increase the involvement of families in activities that promote decision-making and policy planning will be sustained. Contracts will include appropriate activities to boost family involvement as an integral component. Measures of satisfaction with services will also be included where appropriate.

Family advisors will continue to be recruited, mentored, and provided with opportunities to take leadership roles within the areas of the national performance measures, with a focus on Medical Home, Adolescent Transition, Bright Futures, Family Voices, WFFN, Parent to Parent, Fathers

Network, On Line Access Project, Autism Task Force, Family Leadership Team, and Family to Family Health Information Center. Scholarships will be provided to parents to attend IECC, Duncan Seminar, and other selected conferences and trainings.

Family to Family Health Information Center partnership and the Autism Task Force will be a focus in the coming year. Family leaders will use the assessment of family leadership training activities and the Web site analysis conducted in the previous year to select priority areas of activity and development.

Quarterly Communication Network meetings will continue to promote parent involvement as regular participants as well as presenters of specific topics of interest to the group. The network of community-based feeding teams with parents as members will continue to be supported through a contract with the UW. (Fig. 4a, NPM 2, Act. 2)

Performance Measure 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

Last Year's Accomplishments:

The CSHCN section contracted with CHRMC to publish local and statewide data from the National Survey of CSHCN, county profiles, and other data sources. CSHCN introduced the publication at a conference in May 2005 and released it in July 2005. (Fig. 4a, NPM 3, Act. 1)

CSHCN continued to support the activities of Medical Home Leadership Network (MHLN) through funding, staff involvement, and leadership from CSHCN staff. CSHCN contracted with MHLN to conduct key informant interviews of medical home physician team members in order to identify targeted education strategies for promoting medical homes, recruiting new medical home teams, and building the agenda for the Fall 2004 action meeting. Additionally, MHLN analyzed data from the 2004 key informant interviews of parents who attended the CHDD Clinic to provide medical home strategies for outpatient clinic settings. An evaluation of the Child Health Notes was completed. Family members of MHLN teams and the project's co-director participated in the Family Leadership Institute where they received training on the national performance measure on medical homes.

CSHCN identified methods to better integrate the MHLN with the CSHCN Nutrition Network and network of community-based feeding teams.

The CSHCN section contracted with the Mary Bridge Children's Hospital and Health Center (MBCHHC) to disseminate and provide training on two publications about low birth weight. One thousand four hundred copies of The "Critical Elements of Care" and "Watching your Low Birth Weight Infant Grow" were marketed and distributed to a number of professional associations.

WISE Grant pilot sites concluded their test care coordination models. The CSHCN section completed an assessment of the WISE Grant (2002-2005) and developed final recommendations

to improve state services for children with special health care needs. The recommendations were distributed to key stakeholders and included information regarding care coordination, common application, data integration, and blended funding.

The CSHCN section continued to support the Maxillofacial Review Teams and provide opportunities for training, technical assistance, resources, and materials to local CSHCN Coordinators. CHRMC developed a Fact Sheet for medical providers to improve early identification of cleft palates. CSHCN's Contract with the Maxillofacial Review Teams encouraged review boards to promote family-centered care and medical homes.

Seventeen of the 21 medical home teams in communities across the state include the local CSHCN Coordinator. One local team developed and promoted a resource guide for providers. Another team developed an Individualized Health Plan that includes a picture of the child; information presented in the first person; parent's visions for their child's future; and updated medical information. (Fig. 4a, NPM 3, Act. 3)

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with MCH Assessment to provide analysis of available data on children with special needs, including the NS-CSHCN, the NS-Children's Health and other Washington State data sources.				X
2. Contract with the MHLN to support the Medical Home website, increase awareness of medical homes statewide and build the medical home leadership network.				X
3. Contract with LHJs for activities that increase awareness of, access to, and staff participation in medical homes within their communities.		X		

Current Activities:

The CSHCN section contracted with CHRMC to review available data and develop additional evaluation measurements for this performance measure. A user friendly tool will be ready in June that measures attainment of the strategic goals of the CSHCN section and refines reporting capabilities regarding the National Performance Measures for CSHCN. (Fig. 4a, NPM 3, Act. 1)

The CSHCN section incorporated findings from the WISE Grant into care coordination system activities across state agencies, and contracted with the Center for Children with Special Needs to assemble, disseminate, and evaluate care coordination tools. These tools are posted on their Web site. The CSHCN section's Nutrition Consultant is working with contractors to compose a plan to better integrate the MHLN with the CSHCN Nutrition Network and the network of community-based feeding teams. (Fig. 4a, NPM 3, Act. 2)

The importance of medical homes for all children will continue to be a topic of CSHCN Coordinator meetings both regionally and at the state level. Information gathered from the MHLN evaluation survey was shared with all CSHCN Coordinators and the MHLN project coordination attended Regional CSHCN Coordinator meetings to publicize the medicalhome.org Web site and Child Health Notes. Medical home team participation was encouraged as part of the CSHCN Coordinator's public health role in the community.

A grant proposal utilizing recommendations from the WISE Grant to increase the state's capacity for providing enhanced care coordination within a medical home was submitted but not funded.

The CSHCN section continues to support the Maxillofacial Review Boards and provides ongoing information regarding medical homes. Increasing family-centered care continues to be written into maxillofacial contracts. (Fig. 4a, NPM 3, Act. 3)

Plan for the Coming Year:

Work with MCH Assessment to provide analysis of available data on medical homes for children with special needs, including the NS-CSHCN, the NS-Children's Health, and other Washington State data sources. (Fig. 4a, NPM 3, Act. 1)

The 2006-2010 Washington State Medical Home State Plan has been revised and will be implemented and monitored this coming year. Parents and representatives from state agencies, the Washington Chapter of the American Academy of Pediatricians (AAP), the Early Childhood Systems Grant, medical home teams, and health plans developed the plan. Efforts will focus on three strategic areas: 1) Promotion and Endorsement, 2) Performance and Quality, and 3) Financing.

Recommendations from the WISE Grant will continue to be woven into strategic planning activities for the program, interagency collaborative efforts, agency-supported legislative proposals, and future grant proposals. The CSHCN section will work with the Catalyst Center and strategic state partners to develop financing strategies for care coordination within the medical home model.

Activities that will occur this year include: development of a marketing plan and tools for providers and families to use in marketing medical homes; a conference of the existing medical home teams who are part of the Medical Home Leadership Network; and convergence of workgroups to address reimbursement for care coordination and involvement of families at all levels of the strategic plan. A logic model, created from this plan, will guide the development of an evaluation plan. The evaluation plan will track progress on achieving the objectives and will be monitored with the indicators selected in the past year. (Fig. 4a, NPM 3, Act. 2)

Through contracts, the CSHCN section will support the Maxillofacial Review Boards and their efforts to provide family-centered care in a medical setting, including continuing to provide current and innovative information about medical homes.

A CSHCN section staff member will provide leadership for a DOH initiative to promote the medical home approach to health care for all residents of Washington State. The governor's priorities prompted the creation of this initiative.

Local health jurisdictions (LHJs) will be encouraged to continue as part of each one's local medical home team. In communities without a medical home team, the CSHCN section will promote and support ongoing efforts by public health nurses to increase community providers' involvement in the spectrum of care for children with special needs. (Fig. 4a, NPM 3, Act. 3)

National Performance Measure 04: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

Last Year's Accomplishments:

To assist in the development of the MCH 5 Year Needs Assessment, additional insurance data from the National Survey of CSHCN was analyzed for use in planning priorities. In anticipation of the release of the 2005 National Survey of CSHCN, strategies for further analysis of the data and use of insurance data were considered for inclusion in the state publication released in 2005.

Insurance coverage was specifically addressed in the 2005 Children and Youth with Special Health Care Needs Data Report. Data included insurance indicators derived from the National Survey of CSHCN and percent of children served by our state's Medicaid program by county. (Fig. 4a, NPM 4, Act. 1)

Through the CSHCN section's contract with Strategic Services, ongoing technical assistance and training was provided for the Child Health Intake Form (CHIF) database, a statewide database of children served by the CSHCN. Revisions to the software and enforcement of rules regarding data entry improved quality and comparability of statewide data, including data about insurance coverage.

CSHCN continued to provide limited diagnostic and treatment funds to fill the gaps in medically necessary services not covered by any other source.

The CSHCN section's Nutrition Consultant worked with CHRMC and other pilot sites to collect nutrition assessment data on children with special needs. Two reports resulted from the collection of these data: 1) a draft report based data collected in Spokane from 1996-2003 and 2) a final report on CSHCN Special Formula Fund usage (1987-2005), which was distributed to CSHCN Coordinators and other stakeholders. (Fig. 4a, NPM 4, Act. 2)

A variety of methods has resulted in increasing collaboration with managed care plans, the most recent of which was that with Group Health Cooperative. The CSHCN section and the Department of Social and Health Services (DSHS) Health and Recovery Services Administration (HRSA) continue to address concerns on coverage issues for children on Medicaid by reviewing systems issues that affect solutions.

The CSHCN section reviewed and updated parent and provider resource information contained in the presentation "Paying the Bills" and presented this at the Infant and Early Childhood Conference. A session on financing for children with special needs was also given by staff from the CSHCN section, the state Medicaid agency, and the state Office of the Insurance Commissioner. (Fig. 4a, NPM 4, Act. 3)

The CSHCN section monitored the use of diagnostic and treatment funds for undocumented children with special health care needs and shared information with partners as appropriate. Information from the anecdotal survey of CSHCN Coordinators on the effects of Medicaid loss for undocumented children was included in the Kaiser Report on Medicaid and the uninsured. (Fig. 4a, NPM 4, Act. 4)

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with MCH Assessment to provide analysis of available data on children with special needs, including the NS-CSHCN, the NS-Children's Health and other Washington State data sources.				X
2. Collect and analyze statewide program information from CHIF and Health Service Authorizations to identify children who have insurance.				X
3. Collaborate through various interagency forums such as Communication Network, Medicaid Integration Team, the Washington Family to Family Health Information Center (Family Voices) and interactions with managed care plans.				X
4. Provide limited diagnostic and treatment funds to fill gaps in services for children with the CSHCN section, including those for undocumented children with special needs.		X		

Current Activities:

The CSHCN section contracted with CHRMC to review available data and develop additional evaluation measurements for this performance measure. The CSHCN section's Nutrition Consultant is working with MCH Assessment staff and dietitians in Spokane to finalize a nutrition report about children with special nutritional needs and services from 1996-2003. (Fig. 4a, NPM 4, Act. 1)

The CSHCN section continues to monitor standards in the Child Health Intake Form data collection system to measure quality, including third-party payment sources for medical coverage. Strategic Services assists local health department staff to improve data quality and to utilize their own data to determine gaps in services.

The CSHCN Nutritionist is contributing to developing an appropriate dissemination plan for the results of nutrition assessment data for children with special health care needs. (Fig. 4a, NPM 4, Act. 2).

Multiple state and local agencies continue to collaborate through various forums such as the CSHCN Communication Network and Medicaid Integration Team (MIT). Collaboration with managed care plans also continues. The section works with a variety of partners to connect with more commercial insurance plans about issues for children with special needs and their families. Legislation to use state funds to provide Medicaid coverage to undocumented children whose families are below 100 percent of the federal poverty level was passed, and the CSHCN section worked with HRSA partners to develop a plan and then assist in outreach enrollment efforts. Local CSHCN Coordinators were contacted by the CSHCN section Manager to alert them to processes and deadlines to assist families. The section is monitoring the effects of this on enrollment in local CSHCN sections. The CSHCN section continues to respond to proposals about coverage issues for children on Medicaid, particularly concerns about changes to Medicaid coverage and reimbursement rates for nutrition products.

By invitation, the CSHCN section will again present information on financing services at the Infant and Early Childhood Conference in early May 2006. (Fig. 4a, NPM 4, Act. 3)

The CSHCN section continues to utilize limited diagnostic and treatment funding for medically necessary services not covered by another source to fill the gaps in services for children with special health care needs, including undocumented children. (Fig. 4a, NPM 4, Act. 4)

Plan for the Coming Year:

Work with MCH Assessment to provide analysis of available insurance coverage data on children with special needs including the NS-CSHCN, the NS-Children's Health, and other Washington State data sources.

The CSHCN section will continue to monitor standards in the Child Health Intake Form (CHIF) data collection system to assess data quality, including data on third-party payment sources for medical coverage. Strategic Services will continue to assist LHJ staff in reporting requirements. (Fig. 4a, NPM 4, Act. 2).

The CSHCN Communication Network will continue as a venue to discuss and share information and concerns regarding access and financial coverage. The CSHCN section will also continue to work with the Medicaid program and other programs serving children with special needs, such as Foster Care and Early Intervention, to work on solutions to problems related to access to and coverage for care. The section will partner with the Family to Family Health Information Center, Family Voices, WFFN, Parent to Parent, Washington State Father's Network (WSFN), WithinReach (formerly HMHB), and other partners to increase families' access to information about financing, insurance, and navigation of the health care system. The section will continue to address coverage issues for children on Medicaid, particularly concerns about the new changes to Medicaid coverage and reimbursement rates for nutrition products. (Fig. 4a, NPM 4, Act. 3)

Limited diagnostic and treatment funding for medically necessary services not covered by another other source will continue to be set aside in order to fill the gaps in services for children with special health care needs. (Fig. 4a, NPM 4, Act. 4)

National Performance Measure 05: Percent of children with special health needs age 0 to 18 whose families report the community-based services systems are organized so they can use them easily. (CSHCN Survey)

Last Year's Accomplishments:

CHRMCM completed the "Children & Youth with Special Health Care Needs 2005: Washington State Report." The report contains data from the National Survey of CSHCN, county profiles, and results of other assessment activities. CHRMCM released the report in the summer of 2005.

In response to the maternal and child health (MCH) 5-Year Needs Assessment, additional data from the National Survey of CSHCN were analyzed for planning priorities. (Fig. 4a, NPM 5, Act. 1)

WISE Grant sites ended their care coordination pilots. A final evaluation of the pilot site projects included family interviews and feedback on community-based services. The WISE Grant subcommittees developed recommendations on care coordination, integrated data, and common enrollment. A grant proposal to develop a Web-based common application portal was submitted but not funded. (Fig. 4a, NPM 5, Act. 2)

The CSHCN section developed better ways of integrating the Medical Home Leadership Network with the CSHCN Nutrition Network and community-based feeding teams. This improved access to coordinated services for families and their children.

The CSHCN Communication Network, which includes representatives from local CSHCN programs, state agencies, health plans and contractors, and family organizations met regularly. One recent meeting focused on possible solutions to problems related to transition from early intervention to school programs.

A statewide CSHCN Coordinator conference in May 2005 focused on partnerships and integration of care for children. It featured a model for successful community collaborations between Parent to Parent and CSHCN Coordinators. Other conference topics included data, autism, grief and loss, treatment for premature infants, and social marketing. Information booths included non-profit and family organizations.

CSHCN Coordinators who are members of local Interagency Coordinating Councils (ICCs) and Head Start boards act as Family Resources Coordinators and develop resource directories. Other examples from some of the LHJs include: convening health providers and school staff to discuss issues and reaching out to tribal school staff and parents to increase awareness of LHJ programs and services.

The CSHCN section continued to assist the WorkFirst Program at DSHS with collecting and

summarizing information to identify gaps in services for families of children with special needs. (Fig. 4a, NPM 5, Act. 3).

The CSHCN section supported the infrastructure of 14 neurodevelopmental centers (NDCs), the ASK Line, and other contractors in order to obtain information about children and their families. (Fig. 4a, NPM 5, Act. 4)

The Legislature mandated the formation of the Caring for Washington Individuals with Autism Task Force. CSHCN identified parents, representatives from state agencies and school districts, State Representatives and Senators, and academic researchers and clinical practitioners to form the task force.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with MCH Assessment to provide analysis of available data on children with special needs, including the NS-CSHCN, the NS-Children's Health and other Washington State data sources.			X	
2. Develop and implement strategies using the outcome evaluation from WISE pilots and other sources regarding community care coordination.			X	
3. Maintain the network of CSHCN Coordinators and interagency collaborations to provide forums for system improvement that include families as partners; and provide learning opportunities about local, state and national systems for children with special needs.				X
4. Contract with Neurodevelopmental Centers (NDCs) to support community-based collaborations among NDCs, local health agencies, and other partners.	X			

Current Activities:

The CSHCN section continues its contract with CHRMC to review available data and develop additional baseline measurements to provide additional information on this performance measure. (Fig. 4a, NPM 5, Act. 1)

The CSHCN section completed an assessment of the WISE Grant and recommended options for improving state services for children with special health care needs. The recommendations were disseminated to key stakeholders along with information regarding care coordination, common application, data integration, and blended funding. (Fig. 4a, NPM 5, Act. 2)

Interagency collaboration between the CSHCN section, DSHS, and the local CSHCN Coordinators continues with the WorkFirst Children with Special Needs Initiative, which provides services to children and families participating in the WorkFirst Program. The CSHCN

section continues collecting and summarizing information to identify gaps in services for families of children with special health care needs.

The CSHCN section continues to promote the inclusion of families as partners with CSHCN Coordinators and with other state agencies. Family representatives participate on panel presentations and in workgroups as appropriate. Several activities serve to better integrate the network of community-based feeding teams into both the CSHCN Nutrition Network and the MHLN teams to improve access for children seen by feeding teams to a wider array of community-based services.

CSHCN Coordinators and the CSHCN section are developing tools for providers and families to assist providers in care coordination. Families provide input regarding the care coordination tools. The CSHCN section posted a short-term survey on selected contractors' Web sites to identify types of users, assess gaps in target audiences, and prevent duplication. (Fig. 4a, NPM 5, Act. 3)

CSHCN section continues to support NDCs, the ASK Line, and other contractors in order to maintain current and ongoing sources of reliable information about children and their families. (Fig. 4a, NPM 5, Act. 4)

The CSHCN section provides staff support for the Caring for Washington Individuals with Autism Task Force. Membership includes parents, representatives from state agencies and school districts, State Representatives and Senators, and academic researchers and clinical practitioners. The task force held monthly meetings and heard from panels of experts regarding education, diagnosis, intervention, and health care. The task force also heard from panels of parents of individuals with autism spectrum disorders and individuals living with autism spectrum disorders. Each meeting included an opportunity for public comment, during which several parents and care givers addressed the task force.

Plan for the Coming Year:

The CSHCN section will work with MCH Assessment to analyze available data on community based systems for children with special needs including the National Survey of CSHCN, the National Survey on Children's Health, and other Washington State data sources. (Fig 4a, NPM 5, Act. 1)

Recommendations from the WISE Grant will be woven into strategic planning activities for the section, interagency collaborative efforts, agency-supported legislative proposals, and future grant proposals. (Fig. 4a, NPM 5, Act. 2)

CSHCN section involvement with the ASK Line and On Line Access Project will continue. Three CSHCN family advisors provide input into development of the On Line Access Project. The CSHCN section will involve family advisors in development of the new Medical Home Strategic Plan and spring 2007 conference. CSHCN section will take a lead role in assisting the Washington State Autism Task Force in developing recommendations to improve systems of care for individuals with Autism Spectrum Disorders throughout the lifespan.

The CSHCN section will evaluate the WorkFirst referral process between DSHS Caseworkers and CSHCN Coordinators and share the results of the evaluation with stakeholders.

The CSHCN section will continue to work with the community-based feeding teams and with the CSHCN Nutrition Network and the Medical Home Leadership Network to improve awareness and collaboration. Through these efforts, children and their families who are involved with feeding teams will have more information and access to other community services. (Fig. 4a, NPM 5, Act. 3)

The CSHCN section will develop and implement a new process to identify, contract, and fund NDCs across the state to determine if additional community-based centers can be supported to improve access to services for families. (Fig. 4a, NPM 5, Act. 4)

The Caring for Washington Individuals with Autism Task Force will submit a report and final recommendations to the Governor and state Legislature.

National Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

Last Year's Accomplishments:

The Adolescent Health Transition Resource Notebook was updated to include a section on culturally diverse transition stories, sexuality, and HIPAA regulations/privacy issues. Staff from the Adolescent Health Transition Project (AHTP) shared the information with schools, parent groups, and others who focus on the needs of adolescents with special health care needs.

A new health insurance document was developed in conjunction with the Office of Insurance Commissioner to assist adolescents with special health care needs and their parents as they transition into adulthood.

AHTP staff developed a work plan based on research into the use of youth advisory boards in planning and policy for adolescent services. Exploration of how best to recruit, mentor, and involve youth in addressing issues of importance to adolescents with special needs in this state is ongoing. (Fig. 4a, NPM 6, Act. 1)

In response to the Medical Home State Plan's (MHSP) goals to increase awareness and existence of medical homes for children and adolescents with special needs, AHTP staff drafted a five-year plan to improve adolescent health transition in Washington State. AHTP staff asked for input from the CSHCN section, Child and Adolescent Health (CAH) section, and other partners of the MHSP, including the representatives from the Washington Chapter of the American Academy of Pediatrics, the Center for Children with Special Needs at CHRMC, and family physicians. (Fig. 4a, NPM 6, Act. 2)

The CSHCN section's contract with CHRMC began a process to develop care plans for adolescents. Focus groups of adolescents, parents, and providers were identified to provide further input regarding planning for transition to adult medical care. (Fig 4a, NPM 6, Act. 3)

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with the University of Washington, Adolescent Health Transition Project to provide transition information about federal, state, and community programs and services.				X
2. Partner with the CAH section, OSPI, FEPP, DDD and DVR to enhance transition services and access to them.				X
3. Work with MCH Assessment to provide analysis of available data, including the NS-CSHCN on adolescents with special needs, the Washington State Healthy Youth Survey and other data sources.				X

Current Activities:

The CSHCN section is funding the AHTP at the University of Washington to finalize and begin implementation of a 5 year Strategic Plan for providers, youth, and families to facilitate adolescent transition. The first step in the plan is to convene a Special Interest Group of medical providers who provide care to adolescents with special health care needs as they transition to adult care. Another step in the 5 year plan is to obtain Key Informant interview information from adult providers who have experience in accepting adolescents who have transitioned to adult care. (Fig. 4a, NPM 6, Act. 1)

Through the contract with CHRMC, the CSHCN section developed baseline indicators to more accurately assess the success of adolescents as they transition to adult medical care. (Fig. 4a, NPM 6, Act. 2)

A survey of parents of children with special needs is currently underway through a contract with CHRMC. They survey aims to assess parents' perception of care plans and identify the need to further evaluate how adolescents would use care plans together with their parents and medical providers. (Fig 4a, NPM 6, Act. 3)

Plan for the Coming Year:

The CSHCN section will work with AHTP to continue moving forward on the 5 year Strategic Plan for Adolescent Health transition. MCH Assessment will conduct a survey of providers to assess barriers and needs that may be hindering providers' ability to accept adolescents with special needs into their practices. Providers will also be asked about successes in their practice around adolescents with special needs.

The CSHCN section will conduct a survey among youth with special needs to assess their knowledge of medical care plans and how they would use them. The survey will be based on information obtained from youth focus groups in the past year through a contract with CHRMC.

The Adolescent Transition Notebook will continue to be available on-line and in hard copy for those who work with adolescents with special health care needs. (Fig. 4a, NPM 6, Act. 1)

The CSHCN section will continue to partner with the CAH section of OMCH to refine and implement the Washington State Plan for Youth. OMCH will also partner with medical providers through the AHTP contract to develop practical tools providers may use to assist them in providing care for adolescents as they transition to adult health care. (Fig. 4a, NPM 6, Act. 2)

The CSHCN section will work with MCH Assessment to analyze available data on youth with special needs, including the National Survey of CSHCN, the National Survey on Children's Health, the Healthy Youth Survey, and other Washington State data sources. A white paper will be developed on disability disparities in youth and will be publicized through broader youth initiatives and used to develop strategies for addressing disparities. (Fig. 4a, NPM 6, Act. 3)

National Performance Measure 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Last Year's Accomplishments:

Washington's vaccination coverage rate for children ages 19-35 months for 4:3:1:3:3 was 77.7 percent ($\pm 4.6\%$) in 2004. (National Immunization Survey data)

Native American Tribes with WIC programs had an opportunity to participate in Record Round-Up, a project that included collecting immunization records, referring children for immunizations, and entering data into the CHILD Profile Immunization Registry. (Fig. 4a, NPM 7, Act. 2)

The Immunization Program CHILD Profile (IPCP) section continued to encourage providers to report perinatal hepatitis B infections. Perinatal Hepatitis B Prevention program surveillance showed that maternal HBsAg screening rates remained at 98 percent. The number of infants born to HBsAg+ women completing the 3-dose hepatitis series by age 12 months also remained at 88 percent.

IPCP completed the final stage of testing a new perinatal hepatitis B surveillance database case management system. This module will be linked to the Immunization Registry. As of 2005, laboratories are required to report HBsAg+ test results to LHJs.

IPCP continued to contract with LHJs to complete Assessment Feedback Incentives and eXchange (AFIX) site visits on at least 20 percent of all enrolled immunization provider sites in the state. IPCP provided training for staff and technical assistance as needed. Data regarding

provider immunization coverage rate changes was shared with LHJs. IPCP began strategic planning for AFIX site visits, including increased use of the CPIR. (Fig. 4a, NPM 7, Act. 1)

IPCP continued to build partnerships with tribes and fund efforts to enhance vaccination coverage rates of native populations within the state. Technical assistance was provided regarding Indian Health Services' data system link (RPMS) with the Immunization Registry. IPCP facilitated tribal representation at the American Academy of Pediatrics (AAP) Vaccine Summit. (Fig. 4a, NPM 7, Act. 4)

IPCP worked with the State Board of Health to draft changes to the notifiable conditions rules to ensure that LHJs receive consistent reporting on all cases of hepatitis B.

As of September 30, 2005, the CHILD Profile System sent 557,436 total health and safety mailings to parents of children aged 0--6 years. The mailings included well-child checkup and immunization reminders as well as other parenting information. (Fig. 4a, NPM7, Act. 5)

The percentage of children aged 19--35 months with complete immunizations in the CHILD Profile Immunization Registry increased to 27 percent, compared to 23.8 percent in 2004. Implementation of the provider recruitment plan resulted in 60 percent of providers agreeing to participate in the registry, up from 48 percent in 2004. (Fig. 4a, NPM 7, Act. 6)

Washington partnered with Oregon to plan and implement a 4th DTaP Initiative aimed to increase immunization rates by promoting timely administration of the 4th DTaP dose. Activities included a media campaign and parent and provider education. (Fig. 4a, NPM 7, Act. 7)

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with LHJs and others to complete immunization AFIX visits to enrolled private provider sites.				X
2. Fund a collaborative statewide WIC/IP workgroup and Immunization Record Roundup Project in selected counties.				X
3. Partner with LHJs to conduct population-based surveys to assess immunization levels of two year old children.				X
4. Contract with federally recognized tribes to help build capacity to assess immunization coverage rates.				X
5. Send parents age-specific reminders of the need for well-child checkups and immunizations via CHILD Profile Health Promotion.			X	
6. Maintain and increase the number of				X

health care providers participating in the CHILD Profile Immunization Registry to improve access to historical records and use the system's immunization recommendation schedule.				
7. 4th DTaP Initiative to increase timely administration of the 4 th DTaP dose and overall immunization rates.		X	X	

Current Activities:

Seven local agencies are planning a Locally Designed Activity that involves collaboration between WIC and Immunization programs and will include referring children for immunizations and entering data into the CHILD Profile Immunization Registry.

IPCP is developing a plan to give Early Head Start programs access to the Immunization Registry for immunization record verification and documentation.

IPCP, in coordination with the Asian Pacific Islander (API) task force, is to increase hepatitis B awareness and screening among API in community colleges. IPCP continues to support the Perinatal Hepatitis B Prevention program. IPCP and the OMCH Assessment section are planning to implement a hospital abstract project to evaluate screening and vaccination for infants who are prenatally exposed to hepatitis B.

IPCP contracts with LHJs to complete AFIX site visits on at least 20 percent of all enrolled immunization provider sites in Washington. IPCP provides training for new staff and technical assistance as needed. Data regarding provider immunization coverage rates are shared with LHJs. IPCP continues strategic planning for VFC/AFIX site visits, including increased use of the Immunization Registry. Four regional LHM trainings will be held on AFIX Standards and the new CoCASA software. (Fig. 4a, NPM 7, Act. 1)

IPCP continues to fund interested tribes to participate in projects that include activities to enhance vaccination coverage rates of native populations within the state. Technical assistance is provided regarding the link between RPMS and the Immunization Registry. IPCP will co-host an information table at the Washington State Tribal Leader Health Summit. (Fig. 4a, NPM 7, Act. 4)

IPCP worked with the State Board of Health to adopt changes to the communicable disease rules. Changes included requiring immunity to varicella disease for school and child care entry as of July 1, 2006.

All local public health agencies have contracts with IPCP. LHJs work with local providers to assure proper use and storage of vaccines. Several LHJs administer vaccinations.

CHILD Profile Health Promotion continues working to increase the number of parents of children aged 0--6 years who are sent well-child checkup and immunizations reminders. The goal is to increase distribution from 86 percent to 90 percent. (Fig. 4a, NPM 7, Act. 5)

Currently, 498 (53%) private provider sites and 180 (90%) public sites participate in the CHILD Profile Immunization Registry. The statewide expansion goal for the Immunization Registry is to have 74 percent of providers participating by the end of 2006. (Fig. 4a, NPM7, Act. 6)

IPCP established registry-to-registry data sharing agreements with Idaho and Oregon, ensuring access to immunization information for children near those state borders. (Fig. 4a, NPM 7, Act. 6)

IPCP continues to support a media campaign and parent and provider education related to the 4th DTap Initiative. (Fig. 4a, NPM 7, Act. 7)

Plan for the Coming Year:

IPCP will seek funding to in the 2007 CDC Federal Immunization Grant to support Locally Designed Activities that involve collaboration between WIC and Immunization programs and include referring children for immunizations and entering data into the Immunization Registry. (Fig. 4a, NPM 7, Act. 2)

During 2007, IPCP will implement a plan to allow Early Head Start programs access to the Immunization Registry for immunization record verification and documentation.

IPCP and the OMCH Assessment section will continue to collaborate on a hospital-based review of medical records. Information from the records review will assist focused educational outreach to hospitals and care providers. IPCP and CDC are working on a national-level medical record review for a snapshot of practices in our jurisdictions' hospitals.

IPCP will continue to contract with LHJs to complete AFIX site visits on at least 20 percent of all enrolled immunization provider sites in Washington. IPCP will provide training for new staff and technical assistance as needed. Data regarding provider immunization coverage rates will be shared with LHJs. IPCP will continue strategic planning for VFC/AFIX site visits, including increased use of the Immunization Registry. (Fig. 4a, NPM 7, Act. 1)

IPCP will continue to fund interested Washington tribes to participate in projects that include activities to enhance vaccination coverage rates of native populations within the state. Technical assistance will be provided as needed. IPCP will continue to participate in the Washington State American Indian Health Commission. (Fig. 4a, NPM 7, Act. 4)

IPCP will continue working with the State Board of Health to adopt changes to the communicable disease rules. These changes will update school and child care entry requirements for diphtheria, tetanus, and pertussis to be consistent with the Advisory Committee on Immunization Practice's 2006 Recommended Childhood and Adolescent Immunization Schedule.

All local public health agencies will continue to have contracts with IPCP. LHJs will continue to work with local providers to ensure proper use and storage of vaccines. Several LHJs will

continue to administer vaccinations directly to community members.

CHILD Profile Health Promotion will continue working to increase the number of parents of children ages birth-6 years who are sent well child checkup and immunizations reminders. (Fig. 4a, NPM 7, Act. 5)

Implementation of the CHILD Profile Immunization Registry provider recruitment plan will continue. The statewide expansion goal for the Immunization Registry is to have 95 percent of providers participating by the end of 2007. (Fig. 4a, NPM 7, Act. 6)

IPCP will continue to make progress toward the Healthy People 2010 objective of 80 percent immunization rates of children aged 19--35 months for the 4:3:1:3:3 series. (Fig. 4a, NPM 7, Acts. 5, 7)

National Performance Measure 08: The rate of birth (per 1000) for teenagers aged 15 through 17 years.

Last Year's Accomplishments:

Three teen pregnancy prevention project sites in five separate counties implemented community-based interventions with a family planning component. Sites were awarded additional funding after successful completion of the initial 12-month project period. Annual project evaluation and monitoring continued. (Fig. 4a, NPM 8, Act. 1)

The CAH section contracted with a private media firm to launch a statewide abstinence education public awareness campaign in April 2005. Results from focus groups conducted in 2004 served as the basis for the campaign.

An abstinence-focused peer-to-peer media literacy curriculum was extended to additional communities after a successful pilot period. CAH continued to monitor and evaluate new sites to assess effectiveness. (Fig. 4a, NPM 8, Act. 2 and 3)

LHJs worked with pregnant and parenting teens to build their parenting skills and help them with issues around planning future pregnancies. One LHJ provided local statistics related to teen pregnancy to broadcast media to help increase awareness of the issue and of community resources in their remote area. A large metropolitan LHJ provided 15 postpartum visits to all first time teen mothers. The visits aimed to encourage teen moms to stay in school and reduce or delay subsequent pregnancies. (Fig. 4a, NPM 8, Act. 4)

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Select, fund, and evaluate 3 – 5 sites for the teen pregnancy prevention project, which targets youth in high risk situations and incorporates community-based	X	X		

interventions with a family planning component.				
2. Implement and monitor the abstinence-focused statewide public awareness campaign “No Sex No Problems” that targets youth ages 10 through 14 years and parents of young teens.			X	
3. Expand use of abstinence-focused media literacy curriculum (TISAM) to 12 community-based sites and continue evaluation.		X		
4. Partner with state and local agencies to continue to provide technical assistance, consultation and build capacity around comprehensive sex education through the use of DOH-OSPI Guidelines for at least three community sites.				X

Current Activities:

CAH refined and implemented the second phase of a statewide abstinence education public awareness campaign that targeted younger youth and parents. The campaign was launched in January 2006 and will last until September 2006. Post-campaign evaluation results from last year show that 65 percent of youth surveyed remembered the campaign's specific headline.

An abstinence-focused peer-to-peer media literacy curriculum was extended from a few pilot sites to at least 12 communities statewide. Evaluation and monitoring of new sites to ascertain effectiveness continues. Evaluation results from last year indicate that youth receiving curriculum lessons were more likely to report ability to remain in control of decisions towards sex and towards resisting peer pressure. (Fig. 4a, NPM 8, Act. 2 and 3)

The availability of federal funding allowed the three teen pregnancy prevention project sites (in five separate counties) to continue to implement community-based interventions with a family planning component after successful completion of their initial 12-month project period. However, because of limited funding, other sites were not selected. Evaluation and monitoring continues on an annual basis. (Fig. 4a, NPM 8, Act. 1)

CAH also partnered with other state agencies and local organizations and received a grant from the Centers for Disease Control and Prevention to provide technical assistance to and build capacity for local communities around comprehensive sexuality education. The grant provides \$160,000 per year for the next five years. The primary goal of this grant is to enhance, broaden,

and measure the use of the DOH-Office of the Superintendent of Public Instruction (OSPI) Guidelines for Sexual Health Information and Disease Prevention. (Fig. 4a, NPM 8, Act. 4)

Plan for the Coming Year:

Contingent on the availability of funds OMCH will continue to refine and implement a statewide public awareness campaign targeting younger youth and parents of young teens. New approaches and campaign messages may be designed. Depending on the evaluation results from the second phase of the campaign, new approaches and messages may be field tested prior to launching the campaign. OMCH hopes to continue funding community sites to implement an abstinence-focused media literacy curriculum. Curriculum improvements and changes will be made based on evaluation results. Site evaluations and monitoring will be sustained to ascertain program efficacy. (Fig. 4a, NPM 8, Act. 2 and 3)

Contingent on the availability of federal funding, three teen pregnancy prevention project sites (in five separate counties) will continue to implement community-based interventions with a family planning component. Evaluation results from the previous year will dictate programmatic changes to improve program effectiveness. Evaluation and monitoring will be sustained on an annual basis. (Fig. 4a, NPM 8, Act. 1)

OMCH will continue its partnership with other agencies and local organizations to provide technical assistance, consultation and build capacity around comprehensive sex education through the use of DOH-OSPI Guidelines for at least three community sites in the upcoming year. (Fig. 4a, NPM 8, Act. 4)

National Performance Measure 09 – Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Last Year's Accomplishments

In October 2004, Smile Survey screeners and LHJs were trained to use the "Epi-Info" oral health software for recording data. In 2005, Smile Survey data, including data about sealants on molars for third graders, were collected in elementary schools and child care centers.

OMCH and the Health Systems Quality Assurance (HSQA) Division evaluated the implementation and progress of legislation that expanded the scope of practice for dental hygienists to apply sealants and fluoride varnish in schools with general supervision and for dental assistants to do the same under close supervision.

OMCH continued to contract with the University of Washington (UW) School of Dentistry for expert assistance in developing the oral health component of the state adolescent health plan. UW also facilitated an interagency effort among DOH, DSHS, and OSPI to identify early intervention opportunities for children's oral health.

The Health Resources and Services Administration (HRSA) State Oral Health Collaborative Systems (SOHCS) grant funding was used to conduct and analyze the 2005 Smile Survey data. We started development of an OMCH Oral Health Strategic Plan, including a logic model for the school-based dental sealant program.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate results from the 2005 State Smile Survey.				X
2. Develop a state oral health surveillance system to monitor dental sealants and other oral health indicators.				X
3. Review Medicaid and other data on provision of sealants through annual consultation with DSHS, HRSA.				X
4. Provide funding to all LHJs through MCH consolidated contracts; LHJ activities may include support for, and referral to, sealant programs.		X	X	
5. Implement and evaluate the OMCH Oral Health Strategic Plan.				X

Current Activities:

Smile Survey data were analyzed and a report was published in February 2006. The Smile Survey report was disseminated in the state through an official press release. (Fig. 4a, NPM 9, Act. 1)

OMCH is implementing a statewide surveillance system to monitor the prevalence of dental sealants and other oral health indicators. A document on oral disease burden will describe the information contained in the surveillance system in a reader-friendly format and be disseminated to the public, health professionals, and policy makers. (Fig. 4a, NPM 9, Act. 2)

OMCH oral health staff is reviewing Medicaid and other data on provision of sealants through annual consultation with DSHS HRSA and private providers delivering services in schools. (Fig. 4a, NPM 9, Act. 3)

OMCH and HSQA submitted a report to the State Legislature in December 2005 on the school-based Dental Sealant Programs.

Under the continuing SOHCS grant, we are implementing the OMCH Oral Health Strategic Plan, which aims to more fully incorporate oral health into the six different sections of OMCH. We are disseminating the completed OMCH Oral Health Strategic Plan to key stakeholders and will evaluate the plan. (Fig. 4a, NPM 9, Act. 5)

One member of the Oral Health Program staff is assigned as the state sealant coordinator. The coordinator's role is to promote and coordinate sealant programs around the state.

OMCH offers oral health funding to all LHJs through the consolidated contracts process. LHJ activities may include support for, and referral to, sealant programs. (Fig. 4a, NPM 9, Act. 4)

Plan for the Coming Year:

The state sealant coordinator will work with LHJs and local communities to promote and implement new sealant programs.

The coordinator will put in to place a statewide data collection system for the school based sealant program.

National Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

Last Year's Accomplishments:

Although state funding that supports the Child Death Review (CDR) program was eliminated from the state budget in July 2004, 20 of the 30 LHJs that had CDR teams continued to do some CDR work even without state funding support. CDR is a community process that reviews information about unexpected deaths of children, such as motor vehicle crash deaths, in order to make prevention recommendations. (Fig. 4a, NPM 10, Act. 3)

CHILD Profile health promotion materials including information about car seats, booster seats, air bag, and vehicle safety were sent to parents of children 0-6 years. CHILD Profile also partnered with the Washington Traffic Safety Commission and Children's Hospital to revise and mail a brochure on booster seat promotion. (Fig. 4a, NPM 10, Act. 1)

OMCH continued to maintain the CDR web-based reporting system and provide limited technical assistance for local teams. Aggregate data reports and prevention strategies are provided to numerous requesters using CDR data. (Fig. 4a, NPM 10, Act. 4)

A number of LHJs used MCH Block Grant funds to focus on motor vehicle safety activities, including providing inspections and free and reduced-cost car seats. (Fig 4a, NPM 10, Act. 2)

Other activities included one LHJ who supported training for a staff member on safe transport of children with special health care needs, then provided outreach to community providers about safe transport options. Another LHJ provided car seat safety education in Spanish for parents. A third LHJ did a needs assessment that showed a gap in car seat safety education and support. In response, they actively increased outreach and community visibility. (Fig 4a, NPM 10, Act. 2)

OMCH staff continued to collaborate with the Prevention and Trauma section of the DOH Office of Emergency Medical Services (EMS) and Trauma on activities that are common priorities for both programs. (Fig. 4a, NPM 10, Act. 6)

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Disseminate car seat, booster seat, and air bag safety information to parents statewide through CHILD Profile.			X	
2. Promote the use of car seats, booster seats, and other motor vehicle safety information and activities by LHJs.			X	
3. Continue CDR reviews by local teams				X
4. Conduct surveillance of motor vehicle crash deaths to children through CDR process and disseminate data.				X
5. Participate in Harborview Injury Prevention grant.				X
6. Collaborate with DOH Office of EMS and Trauma to promote statewide injury prevention activities.				X
7. Collaborate with DOH Office of EMS and Trauma to develop State Injury Prevention Plan.				X
8. Provide and disseminate data reports identifying risk factors, population statistics and recommendations.				X

Current Activities:

OMCH works with the 20 local CDR teams that continue to function. The state CDR Web-based reporting system continues to receive support. OMCH Assessment staff responds to requests for data from the CDR data and reporting system. Technical assistance continues to be offered to local teams. (Fig. 4a, NPM 10, Act. 3, 4)

CHILD Profile continues sending car seat, booster seat, and air bag safety information to parents of children 0 -- 6 years of age. Vehicle safety information is currently provided in nine CHILD Profile letters and five inserts. The information is refined as statewide data and laws change. (Fig. 4a, NPM 10, Act. 1)

OMCH Assessment published "The Adolescent Needs Assessment" in March 2006, which included data on youth risk factors associated with motor vehicle crashes. (Fig. 4a, NPM 10, Act. 8)

A number of LHJs used MCH Block Grant funds to focus on motor vehicle safety activities, including providing inspections and free and reduced-cost car seats. (Fig 4a, NPM 10, Act. 2)

OMCH participates in an advisory capacity to the Harborview Injury Prevention Resource Center to support a Centers for Disease Control and Prevention demonstration project with six local CDR teams. The project links regional EMS injury prevention coordinators to local teams. Additionally, this project is developing a data analysis and decision-making tool to help CDR teams generate prevention recommendations. The tool is currently being pilot tested.

(Fig. 4a, NPM 10, Act. 5)

OMCH staff continue to collaborate with the DOH Office of EMS and Trauma, Prevention and Trauma section on activities that are common priorities for both programs including development of a State Injury Prevention Plan. (Fig. 4a, NPM 10, Act. 6, 7)

Plan for the Coming Year:

OMCH will work with the 20 local CDR teams that are continuing to function. Technical assistance will continue to be offered to local teams. The state database and reporting system will continue to be supported for now. OMCH staff will participate with the National MCH Center for CDR to look at the feasibility of using a multi-state database instead of the current web-based system in Washington.

CHILD Profile will continue to send car seat, booster seat, and air bag safety information to parents of children 0 -- 6 years of age. Information will be refined as statewide data changes. (Fig. 4a, NPM 10, Act. 1)

OMCH will continue to participate in an advisory capacity to the Harborview Injury Prevention Resource Center to support a CDC demonstration project with six local CDR teams to link regional EMS injury prevention coordinators to local teams. The data analysis and decision-making tool will be refined and will be used by teams on a voluntary basis as a means of streamlining their review processes. (Fig. 4a, NPM 10, Act. 5)

OMCH will continue to work with LHJs to promote more collaboration and coordination with local injury prevention programs and activities to assist in public education efforts including educating parents. (Fig. 4a, NPM 10, Act. 2)

OMCH staff will continue to collaborate with the Prevention and Trauma section of the DOH Office of EMS and Trauma, on activities that are common priorities for both programs. The State Injury Prevention Plan will be finalized and implementation will begin using community partners to market the plan. (Fig. 4a, NPM 10, Act. 6, 7)

National Performance Measures 11: Percentage of mothers who breastfeed their children at 6 months of age.

Last Year's Accomplishments:

The NPM has changed from the percentage of mothers who initiate breastfeeding to the percentage of mother who breastfeed their infants for at least six months. This focus has changed because the greatest health benefits occur when breastfeeding continues for at least six months. The Healthy People 2010 Objective is to have at least 50 percent of mothers breastfeeding their babies for six months.

First Steps providers were required to talk about breastfeeding with all clients. In August 2005, First Steps introduced new documentation requirements that incorporated breastfeeding as a priority. (Fig. 4a, NPM 11, Act. 1).

At the First Steps ABC training, 85 new Maternity Support Services (MSS) providers received training in breastfeeding support and teaching techniques. (Fig. 4a, NPM 11, Act. 2)

First Steps and WIC teamed up to address issues around breastfeeding. For example, in the Spring/Summer of 2005, 34 MSS staff attended the Evergreen Medical Center lactation training (Fig. 4a, NPM 11, Act. 2).

In addition, three other training opportunities were posted on the First Steps listserv and First Steps and WIC finalized breastfeeding talking points that providers can use with clients. These talking points incorporated DOH handouts that supported women with issues around breastfeeding. (Fig. 4a, NPM 11, Act. 3).

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide breastfeeding support and education to low income women on Medicaid through First Steps Maternity Support Services (MSS)	x			
2. Provide training for MSS providers in breastfeeding support and teaching techniques.		x		
3. Recommend lactation support at all hospitals with delivery services through the Perinatal Level of Care Guidelines document.				x
4. Collect National Immunization Survey data that measures breastfeeding rates at six months, trends, and disparities between groups.				x

Current Activities:

All First Steps providers continue to provide basic health messages around breastfeeding. Documentation of specific First Steps issues, such as breastfeeding, is required as of January 1, 2006. (Fig. 4a, NPM 11, Act. 1)

First Steps is currently developing an online breastfeeding training module that offers providers education on how to support women with breastfeeding issues (Fig. 4a, NPM 11, Act. 2).

First Steps is updating a resource guide listing resources for breast pump acquisition. (Fig. 4a, NPM 11, Act. 1)

First Steps and WIC continue to collaborate around breastfeeding by supporting staff to attend the Evergreen Medical Center lactation training, promoting local trainings on breastfeeding support, and reviewing data from WIC and the National Immunization Survey (NIS) regarding breastfeeding for at least six months. (Fig. 4a, NPM 11, Act. 2)

Plan for the Coming Year:

All First Steps providers will continue to provide basic health messages around breastfeeding and document them in the new required forms. (Fig. 4a, NPM 11, Act. 1)

First Steps will distribute MSS provider talking points to help providers with conversations around initiating breastfeeding and supporting long term breastfeeding. (Fig. 4a, NPM 11, Act. 1)

First Steps will distribute an updated resource guide on free breast pump acquisition. (Fig. 4a, NPM 11, Act. 1).

First Steps will test their new online breastfeeding training module with a select group of providers. This module will offer providers education and help them with skills to support women to breastfeed for at least six months. (Fig. 4a, NPM 11, Act. 2)

First Steps and WIC will continue collaborate around breastfeeding and encourage staff to attend the Evergreen Medical Center lactation training, list local training on the First Steps Listserv and DOH Web sites, review WIC and National Immunization Survey data to determines the percentage of mothers who breastfeed for at least six months, and offer talking points that staff can use with medical providers to promote consistent information. (Fig. 4a, NPM 11, Act. 1 and 2)

National Performance Measure 12: Percent of newborns who have been screened for hearing before hospital discharge.

Last Year's Accomplishments

The Early Hearing Loss Detection, Diagnosis, and Intervention (EHDDI) Program continued to add birthing hospitals to Phase I of the Tracking and Surveillance System. By September 30, 2005, 63 of 69 birthing hospitals were part of the system. (Fig. 4a, NPM 12, Act. 1)

Over 88 percent of all infants were screened for hearing loss in 2004, an increase from 81 percent in 2003. (Fig. 4a, NPM 12, Act. 2)

Staff presented data at the 2005 National Early Hearing Detection and Intervention meeting in Atlanta, Georgia. In April 2005, information about Universal Newborn Hearing Screening (UNHS) in Washington State was presented to the Washington State Board of Health. Presentations included information about hearing screening rates, collaborative efforts to support newborn hearing screening, status of the tracking and surveillance system, and ongoing issues related to UNHS in Washington.

The EHDDI program contracted with CHRMC to provide technical assistance to birthing hospitals and with Washington Sensory Disabilities Services (WSDS) to provide ongoing early intervention training to eight counties and the State Migrant Council via interactive videoconferences and on-site coaching. (Fig. 4a, NPM 12, Act. 3)

A second statewide EHDDI Summit was held in August 2005 at Skamania Lodge in Stevenson, Washington. Participants included a variety of professional groups, parents, and members of the deaf community, with representation from every county in Washington. Participants evaluated needs in their regions as well as across the state, and worked together to develop solutions. A final report was made available to participants in February 2006.

CHILD Profile mailed the "Health & Development Record" booklet, which contains spaces to record hearing screening results. CHILD Profile provided health promotion messages in both its 1-month and 3-month letters to encourage parents to speak with their health care provider if they have concerns about their child's hearing. CHILD Profile partnered with the Infant Toddler Early Intervention Program to distribute information on hearing milestones in its 3-month, 6-month, and 12-month mailings.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop an EHDDI tracking and surveillance system.				X
2. Conduct annual newborn hearing screening survey with birthing hospitals across the state.				X
3. Contract with Children's Hospital and Regional Medical Center (CHRMC) to promote universal newborn hearing screening in birthing hospitals.			X	

Current Activities

The EHDDI Program continues to analyze data from Phase I and Phase II of the Tracking and Surveillance system. To date, 65 of 69 birthing hospitals are reporting hearing screening data to the EHDDI Program. The remaining four hospitals include one hospital in Southwest Washington that is not screening infants for hearing loss and three military hospitals that currently contract with Oregon. We hope to add the hospital in Southwest Washington to Washington's tracking and surveillance system before July 2006.

To date, an estimated 95 percent of all infants born in Washington received a hearing screening at birth. The average age of the infants upon initial screening, excluding those in the neonatal intensive care unit (NICU), was 1.5 days. Of those who did not pass their initial screen, 66 percent had rescreen outcomes recorded in the EHDDI tracking and surveillance system. The average age at rescreen for non-NICU infants was 15.5 days. (Fig. 4a, NPM 12, Act. 1)

During the summer of 2006, pediatric audiologists will review "Best Practices for Audiological Evaluation in Newborns" to determine if any changes or updates are needed.

OMCH will conduct a parent survey in the summer of 2006 to evaluate cultural competency of services accessed as well as reasons why recommended services were not accessed.

Through a contract with WSDS, early intervention provider training was expanded to include 10 additional counties, mostly in rural areas of Eastern Washington. County representatives will participate in an online interactive course called "Improving Early Hearing Detection and Intervention Service Delivery: Infants & Young Children with Hearing Loss, Ages Birth - 5 Years." Masters level trained early intervention providers who specialize in services for children who are Deaf or Hard of Hearing are providing consultation and one-on-one on-site coaching to county participants. The WSDS contract also provided funding for seven families with birth-to-three year olds with hearing loss to attend the annual family weekend May 12-14, 2006 in Ellensburg, WA.

The EHDDI Program continues to contract with CHRMC to provide technical assistance to hospitals with Universal Newborn Hearing Screening Programs. To date, CHRMC has provided technical assistance to over 15 hospitals. In addition, CHRMC is educating hospitals and physicians about the importance of risk factors for late-onset hearing loss. (Fig. 4a, NPM 12, Act. 3)

CHILD Profile continues to mail the "Health and Development Record" booklet, which contains spaces to record hearing screening results. CHILD Profile also continues to provide health promotion messages in its 1-month and 3-month letters to encourage parents to speak with their health care provider if they have concerns about their child's hearing. CHILD Profile maintains its partnership with the Infant Toddler Early Intervention Program to distribute information on hearing milestones in its 3-month, 6-month, and 12-month mailings.

Plan for the Coming Year

The EHDDI Program will continue to analyze data from Phase I and Phase II of the Tracking and Surveillance system to make further improvements to the system and to determine lost to follow-up rates in Washington. (Fig. 4a, NPM 12, Act. 1)

CHRMC will continue to provide technical assistance to hospitals with Universal Newborn Hearing Screening Programs. (Fig. 4a, NPM 12, Act. 3)

Early intervention provider training will be expanded to additional counties through a contract with WSDS. The EHDDI Program will continue to work with CSCHN, Office of the Deaf and Hard of Hearing, DSHS, and local and state Interagency Coordinating Councils to ensure infants are receiving timely and appropriate follow-up services.

CHILD Profile will continue to mail the "Health and Development Record" booklet, which contains spaces to record hearing screening results. CHILD Profile will also continue providing health promotion messages in its letters to encourage parents to speak with their health care provider if they have concerns about their child's hearing. CHILD Profile plans to maintain its partnership with the Infant Toddler Early Intervention Program to distribute information on hearing milestones.

National Performance Measure 13: Percent of children without health insurance.

Last Year's Accomplishments:

The CAH section coordinated with key organizations and agencies to ensure that children, teens, and their families have access to health care services, especially health insurance. CAH administered a contract to support the implementation and evaluation of a program called Kids Get Care, which was designed to increase children's access to health insurance.

CHILD Profile inserted the "Healthy Kids Now" flyer through collaboration with the Health Improvement Partnership. The target population for this flyer was the 4 - 6 year age group. The "Healthy Kids Now" insert provides information on how to access free or low-cost health insurance for children. Dissemination of this flyer through CHILD Profile was responsible for 19 percent of total calls received by the Healthy Kids Now hotline, which receives an average of 285 calls per month. (Fig. 4a, NPM 13, Act. 1)

CHILD Profile health promotion letters referred parents to HMHB (now known as WithinReach) to assist them in obtaining medical insurance for their children. (Fig. 4a, NPM 13, Act. 1)

Local efforts to better address the percent of children without health insurance included using assessment data to study insurance status and providing free services to a limited number of uninsured clients. To improve clients' access to health insurance and coordinated health care services, LHJ staff assisted clients with applying for public insurance and helped them work with insurers. Families also received help with accessing transportation and interpreter services through Medicaid. Non-English speaking families, especially those new to the state, often face barriers to health care because they cannot communicate. LHJs are key in helping them with both information and in building confidence in their own ability to access services.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate with other key organizations and agencies to ensure that children, teens, and their families have access to health care services.				X
2. Facilitate a state-level meeting to develop a plan to improve utilization of the Medicaid Early and Periodic Screening, Diagnostic, and Treatment program.				X

Current Activities:

CAH continues to coordinate with other key organizations and agencies to ensure that children, teens, and their families have access to health care services, especially health insurance. (Fig. 4a, NPM 13, Act. 1)

CAH will partner with Medicaid to facilitate a state-level meeting to develop a plan to improve utilization of the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. (Fig. 4a, NPM 13, Act. 2)

CHILD Profile continues to disseminate the "Healthy Kids Now" insert in the health promotion mailings to provide parents with information on how to access free or low-cost health insurance for children. CHILD Profile health promotion letters refer parents to WithinReach (formerly HMHB) to assist them in obtaining medical insurance for their children. (Fig. 4a, NPM 13, Act. 1)

Plan for the Coming Year:

CAH will work with key organizations and agencies to implement a plan to improve utilization of EPSDT services. (Fig. 4a, NPM 13, Act 2).

CAH will coordinate with other key partners to ensure that children, teens, and their families have access to health care services, especially health insurance.

National Performance Measure 14: Percent of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile

Last Year's Accomplishments

This is a new performance measure, there were no related activities last year.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate nutrition and physical activity information to parents statewide through CHILD Profile			X	
2. Coordinate with internal and external partners to promote nutrition and physical activity				X
3. Child care health consultants continue to provide training and consultation regarding nutrition and physical activity				X
4. Promote use of Bright Futures guidelines including Physical Activity and Nutrition.				X

Current activities:

CHILD Profile materials are mailed to parents of children birth to six years old. These mailings contain age-appropriate nutrition information, including two nutrition brochures. Physical activity information is incorporated into materials on child growth and development. (Fig 4a NPM 14, Act. 1)

OMCH seeks opportunities to coordinate with internal and external partners around nutrition, physical activity, and obesity prevention. Examples include the DOH Nutrition and Physical Activity Policy Leadership Group and the Washington State Nutrition and Physical Activity Plan. (Fig 4a NPM 14, Act. 2)

Child care health consultants provide nutrition and physical activity information to child care providers. Detailed training is included in the child care health consultation education modules. (Fig 4a NPM 14, Act. 3)

OMCH is actively promoting the use of Bright Futures Health Promotion guidelines including those related to physical activity and nutrition. These two topics were chosen by some participants in the Bright Futures Early Childhood Project as areas of emphasis. The Early Childhood Project was designed to increase the use of Bright Futures in settings such as Head Start, Early Head Start, and the state preschool program. (Fig 4a NPM 14, act. 4)

MSS works to promote a healthy weight during pregnancy and appropriate physical activity to improve birth outcomes. MSS also promotes breastfeeding which helps to reduce the chances of overweight/obesity in children.

Plans for the coming year:

OMCH plans to continue activities to promote nutrition and physical activity, including participating in and coordinating with internal and external groups working to promote healthy activities and prevent obesity in children and youth of all ages, their parents, and pregnant women.

National Performance Measure 15: Percent of women who smoke in the last three months of pregnancy.**Last Year's Accomplishments:**

This NPM is new. The following are related activities from last year's State Performance Measure 2. OMCH provided information to health care professionals about the Medicaid benefit that aims to increase the number of medical providers who do interventions for tobacco cessation. Information was provided through articles in professional newsletters, medical meeting exhibits, and professional Web sites. Through reports provided by DSHS HRSA, MIH tracked benefit billing data to evaluate how many providers are billing for the intervention. (Fig. 4b, SPM 2, Act. 2, 4 -- See Section IVD. State Performance Measures for this figure)

The MSS smoking cessation performance measure was integrated into a standardized charting system and provider training continued. (Fig. 4b, SPM 2, Act. 1)

MIH, DSHS HRSA, and the DOH Tobacco Prevention and Control Program continued the tobacco Champion Project for ten more First Steps agencies which provided additional motivational interviewing and systems change training, follow-up site visits, and technical assistance. Training and follow-up was completed by June 30, 2005. (Fig. 4b, SPM 2, Act. 8)

PRAMS data were collected and referenced to measure smoking rates before, during, and after pregnancy; quit rates; relapse rates; third trimester smoking trends; and disparities between groups. (Fig. 4b, SPM 2, Act. 6)

Tobacco cessation for pregnant and parenting women and teens was an integral part of LHJ services to clients across the state. Many LHJs were leaders or active participants in their local Tobacco Coalitions. (Fig. 4b, SPM 2, Act 10)

The Tobacco Prevention and Control Program (TPCP) and the Tobacco Cessation Resource Center (TCRC) implemented the Quit Line Fax Back Referral Program. This is available to First Steps and obstetric providers. The provider asks about and documents tobacco use, advises users to quit, and assesses interest in quitting. Those interested in quitting are directly referred to the Washington Tobacco Quit Line using a faxed referral form. The Quit Line contacts the person to assist in developing a quit plan and arrange referrals. MIH worked with March of Dimes and TPCP on several events to inform medical providers and office staff about the fax referral program and Medicaid benefit. In addition, MIH, DSHS HRSA, and TPCP provided intensive training to ten Champion agencies. (Fig 4b, SPM 2, Act 7)

Operators of the Family Health Hotline (formerly HMHB) asked callers if anyone in the home smokes and offered referrals to the Quit Line. From October 2004 through September 2005, 448 callers were referred to the Quit Line. Quit Line pamphlets were included in 3,875 prenatal packets and 1,378 child health packets. (Fig 4b, SPM2, Act 9)

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote the Smoking Cessation benefit for pregnant women through OMCH collaboration with DSHS HRSA.		x		
2. Increase smoking cessation among low income women on Medicaid by providing tobacco cessation intervention training to First Steps providers.				x
3. Collect and reference PRAMS data to measure smoking rates before, during, and after pregnancy; quit rates; relapse rates; third trimester smoking trends; and disparities between groups.				x

4. Inform and educate professionals about the FAX Back Referral program.				X
5. Disseminate the best practice guide for smoking cessation to medical providers.				X
6. Share tobacco data with First Steps providers and perinatal providers.				X
7. WithinReach refers callers with tobacco in their home to the Quit Line and sends tobacco cessation materials to callers as appropriate.			X	
8. Help build coalitions of local partners and support community efforts to decrease tobacco use during pregnancy.				X

Current Activities:

MIH continues to inform providers of the Medicaid benefit through articles in professional newsletters, medical meeting exhibits, and professional Web sites. Through reports provided by DSHS HRSA, MIH is tracking benefit billing data to evaluate how many providers are billing for the intervention. (Fig. 4b, SPM 2, Act. 2, 4)

The MSS smoking cessation performance measure has been integrated into a standardized charting system and provider training continues. (Fig. 4b, SPM 2, Act. 1)

MIH is working with the Tobacco Prevention and Control Program to market the FAX Back Referral program to First Steps agencies and medical providers. For example, staff distributes information at continuing medical education meetings and conducts training for First Steps agencies. (Fig. 4b, SPM 2, Act. 7)

Operators of the WithinReach: Essential Resources for Family Health Family Health Hotline (formerly HMHB) ask callers if anyone in the home smokes, and if so, the operators offer referrals to the Quit Line. WithinReach continues to include Quit Line materials in prenatal packets and child health packets. (Fig 4b, SPM 2, Act 9)

First Steps agencies are receiving enhanced onsite technical assistance (including the Tobacco Champion Project for up to 35 First Step agencies) in order to strengthen working relationships with county tobacco prevention and control contractors; increase utilization of the state Quit Line; increase knowledge and skills in client centered tobacco cessation messages for pregnant women; and develop new policies that reinforce the value of tobacco cessation and protection against secondhand smoke for both staff and clients. Included with this project is an evaluation plan. Consultation continues for all First Steps agencies that participated in the Tobacco Champion Pilot and Project. (Fig 4b, SPM 2, Act 8)

PRAMS data are being collected and referenced to measure smoking rates before, during, and after pregnancy; quit rates; relapse rates; third trimester smoking trends; and disparities between groups. (Fig. 4b, SPM 2, Act. 3, 6)

Plan for the Coming Year:

MIH will continue to inform providers of the Medicaid benefit. (Fig. 4a, NPM 15, Act. 1)

The MSS smoking cessation performance measure will continue to be documented in a standardized charting system and provider training will continue. (Fig. 4b, SPM 2, Act. 1)

PRAMS data will be collected and referenced to measure smoking rates before, during, and after pregnancy; quit rates; relapse rates; third trimester smoking trends; and disparities between groups. (Fig. 4a, NPM 15, Act. 3)

MIH and its partners will inform First Steps providers and medical providers about availability and use of the FAX Back Referral system. (Fig. 4a, NPM 15, Act. 4)

Tobacco Cessation Training will continue for First Steps Providers. (Fig 4a, NPM 15, Act 2)

Continue to disseminate the "Smoking Cessation during Pregnancy" best practice booklet. (Fig. 4a, NPM 15, Act. 5)

WithinReach will continue to offer Quit Line referrals and distribute Quit Line pamphlets. (Fig. 4a, NPM 15, Act 7)

Data about smoking during pregnancy and efforts to reduce smoking during pregnancy are compiled to ensure that quality improvement can be measured over time and shared with providers. (Fig 4a, NPM 15, Act 6)

The Tobacco Champion Project will continue to provide opportunities for First Steps providers to receive additional motivational interviewing and systems change training. (Fig 4a, NPM 15, Act 2).

Some LHJs will continue to receive and use MCH block grant funds to provide smoking cessation activities that target pregnant women. (Fig 4a, NPM 15, Act 8)

National Performance Measure 16 – The rate (per 100,000) of suicide deaths among youths aged 15 to 19 years.**Last Year's Accomplishments:**

OMCH collaborated with the Injury and Violence Prevention Program as well as the Office of Epidemiology to implement an evaluation of the Youth Suicide Prevention Program (YSPP), which included data from the 2002 and 2004 Healthy Youth Survey. YSPP activities focused on raising public awareness, providing gatekeeper training to adults who interact with youth, and building community capacity to address suicide prevention locally and support youth in the community. (Fig. 4a, NPM 16, Act 1, 4)

OMCH supported YSPP activities by: promoting gatekeeper training through LHJs and other networks and partnerships; providing consultation on key questions and issues related to youth

suicide; providing technical assistance and support to communities already engaged in youth suicide prevention efforts; supporting local and statewide efforts to promote early identification of children's mental health issues; incorporating suicide prevention as a key element in the Washington State Plan for Youth; and supporting data collection on risk behaviors through the Healthy Youth Survey. (Fig. 4a, NPM 16, Act. 5)

Most LHJs used Title V block grant funds for women and younger children. However, LHJs in more remote and isolated communities worked with people of all ages in the community. One Southwest Washington rural LHJ has consistently supported youth-focused community awareness and events for youth and long-range community support of youth in their community. In the past few years they have tracked suicides and suicide attempts and worked with the community to create support for youth. During the past year this LHJ assisted in a "youth issues" forum to find ways to provide youth with safe and healthy activities. As a result the community will establish a Boys and Girls Club, create a youth-oriented park, and continue to support a recently built skate park. (Fig. 4a, NPM 16, Act. 7)

OMCH maintained the state database on childhood deaths and provided technical assistance for the twenty local Child Death Review teams that were able to continue after losing state funds. The database continued to list recommendations for strategies directed at prevention of youth suicide. (Fig. 4a, NPM 16, Act. 2, 3)

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with DOH Office of EMS and Trauma to implement Youth Suicide Prevention Program (YSSP).			X	
2. Work with Child Death Review (CDR) local team reviews of unexpected deaths (including suicides).				X
3. Conduct surveillance of suicide deaths through CDR and disseminate data.				X
4. Participate in evaluation of YSPP			X	
5. Promote training and strategies of suicide prevention				X
6. Develop State Injury Prevention Plan				X
7. Support LHJ youth safety activities			X	

Current Activities:

OMCH continues to work with the DOH Office of Emergency Medical Services (EMS) and Trauma on injury and violence prevention to implement YSPP and reduce the teen suicide rate. YSPP activities continue to focus on raising public awareness, providing gatekeeper training to adults who interact with youth, and building community capacity to address suicide prevention. An added area of enhancement of YSPP activities includes 4 Pierce County institutions of higher education with a focus on youth ages 17-24 years. This age group is currently at higher risk than middle school and high school age youth. DOH sponsored two day-long trainings for these institutions in October 2005 and February 2006. (Fig. 4a, NPM 16, Act. 1, 4)

OMCH continues to assist with evaluating the YSPP program by comparing Healthy Youth Survey data from schools implementing the program to schools not utilizing the program. The current evaluation was completed in December 2005. (Fig. 4a, NPM 16, Act. 4)

LHJs continue to use Title V block grant funds to support youth safety activities such as promoting safe storage of firearms and gun safety classes, work with EMS and other first responders on how to respond to a suicide and persons with suicidal behaviors, and work with school personnel on emergency preparedness and safety plans including how to respond to a suicidal youth. (Fig. 4a, NPM 16, Act. 5, 7)

OMCH continues to maintain the state database on childhood deaths and provide technical assistance for the twenty local Child Death Review teams that continue to meet after receiving a cut in their funding. The database continues to list recommendations for strategies directed at prevention of youth suicide. (Fig. 4a, NPM 16, Act. 2 and 3)

OMCH Assessment published "The Adolescent Needs Assessment" in March 2006, which included data on youth risk factors associated with suicide. (Fig. 4a, NPM 16, Act. 3)

OMCH staff continue to collaborate with the Prevention and Trauma section of the DOH Office of EMS and Trauma on activities that are common priorities for both programs including development of a State Injury Prevention Plan. Youth Suicide is one of the focus areas of the plan. (Fig. 4a, NPM 16, Act. 6)

Plan for the Coming Year:

OMCH will continue to work with the Office of EMS and Trauma Systems to implement YSPP throughout the state to reduce the teen suicide rate. Plans are to continue 2006 activities, gain further momentum in raising awareness of the problem of youth suicide, train people who work with youth on the skills for early intervention, and engage communities to address suicide through prevention and early intervention planning and skills building. Efforts will be made to expand efforts statewide through partnerships with the Community Health and Safety Networks as well as with Native American tribes. Additional efforts will continue with college and university campuses in Pierce County to include training and awareness campaigns. (Fig. 4a, NPM 16, Act. 1, 4)

OMCH will assist with evaluating YSPP program efforts by comparing Healthy Youth Survey data from schools with the program to schools without the program. This will be a focus of the program during the last half of 2007. (Fig. 4a, NPM 16, Act. 3)

LHJs will continue to use Title V block grant funds to support various youth safety activities such as promoting safe storage of firearms and gun safety classes, working with EMS and other first responders on how to respond to a suicide, and working with school personnel on emergency preparedness and safety plans including how to respond to a suicidal youth. (Fig. 4a, NPM 16, Act. 5, 7)

OMCH will continue to maintain the state database on child deaths and provide technical assistance for the remaining local Child Death Review Teams. The database will continue to list recommendations for strategies directed at prevention of youth suicide. (Fig. 4a, NPM 16, Act. 2, 3)

OMCH staff will continue to collaborate with the Prevention and Trauma section of the DOH Office of EMS and Trauma on activities that are common priorities for both programs. The State Injury Prevention Plan will be finalized and implementation will begin using community partners to market the plan. In addition, OMCH will apply for grant funding through SAMHSA to expand partner efforts and program activities. (Fig. 4a, NPM 16, Act. 6)

National Performance Measure 17: Percent of VLBW infants delivered at facilities for high-risk deliveries and neonates.

Last Year's Accomplishments:

Regional Perinatal Programs were funded to provide professional education, consultation, and to facilitate transport of high-risk pregnant women and neonates. In the four regional perinatal centers who collect and report these statistics, approximately 600 women were transported to one of four regional perinatal centers for high-risk birth and approximately 400 infants were transported from a community hospital to a regional perinatal center for neonatal intensive care. (Fig. 4a, NPM 17, Act. 2)

Regional Perinatal Programs continued to monitor delivery sites of very low birth weight babies and advocate for delivery of these infants at tertiary care facilities. (Fig. 4a, NPM 17, Act. 1).

In September 2005, the MCH epidemiologist presented statistics to the statewide Perinatal Advisory Committee about where very low birth weight babies were being delivered in the state. About 82 percent of very low birth weight babies were born in tertiary level perinatal facilities in 2003.

Regional Perinatal Programs received funding to provide professional education and consultation and to facilitate transport of high-risk pregnant women and neonates. (Fig. 4a, NPM 17, Act. 2)

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor delivery sites of very low birth weight babies and advocate for delivery of these infants at tertiary care facilities.				x
2. Fund Regional Perinatal Centers to provide professional education, consultation, and facilitate transport of high-risk pregnant women and neonates.		x		
3. Fund Regional Perinatal programs to coordinate and implement QI projects to improve pregnancy outcome statewide, including advocating delivery of VLBW		x		

babies at tertiary level perinatal facilities.				
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Current Activities:

Regional Perinatal Programs are monitoring delivery sites of very low birth weight babies and actively advocating for delivery of these infants at tertiary level perinatal facilities until June 30, 2006. At that time, the regional program focus changes from a primary function of education and consultation to a different function -- that of coordinating and implementing state and regional quality improvement projects focused on decreasing poor pregnancy outcomes for which Medicaid clients are at disproportionately increased risk. (Fig 4a, NPM 17, Act. 3)

Regional Perinatal Program funding was significantly decreased beginning July 1, 2006 and no longer includes activities specifically focused on professional education and consultation or transport of high-risk pregnant women and neonates. However, selected quality improvement projects will function on the premise that very low birth weight babies have better outcomes when born at tertiary level perinatal facilities. (Fig. 4a, NPM 17, Act.1, 3)

Plan for the Coming Year:

Regional Perinatal Programs will begin to implement quality improvement projects aimed at improving poor pregnancy outcomes. Monitoring delivery sites of very low birth weight babies will be important to assessing components that help ensure positive pregnancy outcomes. (Fig. 4a, NPM 17, Act. 1, 3)

Regional Perinatal Programs will receive less funding than in the past, but will continue to function on the premise that outcomes of very low birth weight babies are improved if born at facilities equipped for high-risk deliveries and newborn intensive care. (Fig. 4a, NPM 17, Act. 1, 3)

National Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Last Year's Accomplishments:

The Maternal and Infant Health (MIH) section monitored the rise in medical liability insurance rates. Many obstetricians and family physicians quit obstetric care. MIH monitored this situation and its relationship to access to prenatal care. (Fig. 4a, NPM 18, Act. 4)

OMCH contracted with LHJs to provide services such as referrals and assistance, links with Medicaid and needed prenatal care in the first trimester, and pregnancy tests. Many LHJs provide multiple services including pregnancy testing, family planning and emergency contraception. Women with positive pregnancy tests were referred to First Steps, WIC, and private health care providers. Other LHJ activities included: working with local hospitals to develop a referral system to behavioral health specialists for prenatal clients needing those services; providing "Dental Health for Moms-to-Be" classes to encourage healthy behaviors during pregnancy; and offering childbirth education classes that were attended by 100 women plus their coaches. (Fig. 4a, NPM 18, Act. 3)

Prenatal care utilization data were monitored and distributed to First Steps providers, included in the Perinatal Indicators Report, and shared with the Perinatal Advisory Committee. (Fig. 4a, NPM 18, Act. 4)

The WithinReach: Essential Resources for Family Health, Family Health Hotline responded to 8,301 calls from pregnant women in 2005. One thousand nine hundred and ninety two (24%) of these callers were not in prenatal care. Callers received referrals to the following services: WIC (6,502), Pregnancy Medicaid (2,117), Basic Food (434), Children's Medicaid (535), and others. (Fig. 4a, NPM 18, Act. 1)

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach and education through WithinReach to pregnant women to increase early enrollment in prenatal services.			x	
2. Continue MSS provider referrals to prenatal care if clients are not already enrolled and support women to stay in prenatal care.		x		
3. Continue LHJ provider referrals to prenatal care if clients are not already enrolled and support women to stay in prenatal care.		x		
4. Share prenatal care utilization data with MSS and perinatal providers.				x

Current Activities:

OMCH continues to contract with 35 LHJs to provide maternal and child health services, which include routine referral and assistance linking with Medicaid and needed prenatal care. (Fig. 4a, NPM 18, Act. 3)

Prenatal care utilization data are being monitored and distributed to First Steps providers, included in the Perinatal Indicators Report, and shared with the Perinatal Advisory Committee. (Fig. 4a, NPM 18, Act. 4)

The WithinReach Family Health hotline continues to refer pregnant women for Medicaid eligibility and link to prenatal providers. (Fig. 4a, NPM 18, Act. 1)

Linkage to prenatal care providers continues to be a required MSS activity. (Fig. 4a, NPM 18, Act. 2)

Plan for the Coming Year:

OMCH will contract with LHJs to provide maternal and child health services including routine referrals and assistance linking with Medicaid and needed prenatal care. (Fig. 4a, NPM 18, Act. 3)

Prenatal care utilization data will be monitored and distributed to First Steps providers, included in the Perinatal Indicators Report, and shared with the Perinatal Advisory Committee. (Fig. 4a, NPM 18, Act. 4)

The WithinReach Family Health Hotline will continue to refer pregnant women for Medicaid eligibility and link to prenatal providers. (Fig. 4a, NPM 18, Act. 1)

Linkage to prenatal care providers will remain a required MSS activity. (Fig. 4a, NPM 18, Act. 2)